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ABSTRACT

Home visiting programs provide support services to families in their own homes, touching on social services, education, mental health, nutrition, health, or general welfare concerns. Twenty home visiting programs in California were surveyed to determine standards, best practices, areas needing improvement, and to develop training and support programs for caseworkers. Home visits were found to positively affect health, family functioning, child abuse and neglect, and school readiness. This report reviews findings of the survey and discusses best practices and practices needing review in the areas of engaging families, setting goals with families, and supervising programs to determine family outcomes and staff and volunteer satisfaction. The paper discusses other concerns such as a commitment to an emergent curriculum approach, caseload, peer support, length of service, boundaries between home visitors and families, and training and technical assistance. The paper offers recommendations for improving programs, and training and curriculum guidelines in the areas of engaging families, setting goals, and supervision. A list of participating home visit programs with contact information and sample survey questions is appended. (JPB)

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HEALTHY FAMILIES CALIFORNIA

A REVIEW OF STANDARDS AND BEST PRACTICES IN HOME VISITING PROGRAMS ACROSS CALIFORNIA

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Metro Centre, 1600 Bercut Inn Way, Suite 163, Sacramento, CA 95815
Telephone (916) 648-8010 - Fax (916) 648-8007

STANDARDS AND BEST PRACTICES IN HOME VISITING PROGRAMS

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Linda E. Smith
California Consortium to Prevent Child Abuse
July, 1995

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DEDICATION

To Debra Kenney of Mentor Moms
at the Desert Counseling Clinic
in Ridgecrest, CA.

for her enthusiasm and eagerness to learn.

ACKNOWLEDGMENTS

Thank you to those persons across the state of California and United States who encouraged us to provide this report to the child abuse prevention field. We are particularly grateful for the sage advice of Dr. Deborah Daro, Director of Research at the National Committee to Prevent Child Abuse. Her suggestions were very helpful in keeping this one-year project at a manageable level while still making it relevant to home visit programs.

Thank you to the foundations that provided funding for this project (The Stuart Foundations and Haigh-Scatena Foundations) and to all the foundations providing support for Healthy Families California work over the past three years. (Haigh-Scatena Foundation, The Stuart Foundations, Sierra Health Foundation, The Henry J. Kaiser Foundation, The California Wellness Foundations and A.T. & T.)

Lorraine Lima deserves very special recognition for the outstanding work she did as a consultant to this project. Her interviews and insightful reporting have contributed substantially to the content and usefulness of this survey. Thank you, Lorraine!

Finally, both Lorraine and I say thank you so much to all the programs who agreed to be interviewed for this project. We found wonderfully creative programs abounding with caring, intuitive, positive staff and volunteers. In each program, we found something exciting and worth replicating. From north to south and east to west, the home visitors, supervisors, other staff and volunteers we met re-energized us and confirmed our faith in home visiting as a respectful and gentle intervention with many kinds of families. Thank you again to the staff and volunteers of the programs surveyed for this report. We wish you all continued success!

Linda E. Smith
Healthy Families California
California Consortium to Prevent Child Abuse
July, 1995.

"I GO TO THEIR HOMES. I THINK THE ONLY PLACE YOU CAN EFFECT A CHANGE - IS ON THEIR OWN TURF."

Home Visitor

CHAPTER 1

INTRODUCTION

The term **Home Visiting** is used to describe services provided to families in their own homes, instead of the more traditional methods of seeing the family or individual at an agency. Home visiting provides the chance for staff to have a greater understanding of families through visiting them in their own homes. Seeing, touching, smelling the environment as well as talking and listening to the family provide the basis for a holistic evaluation of problems and concerns. Home visiting can focus on social services, education, mental health, nutrition, health or general welfare of families. It can be provided through several models. Prevention models work toward goals such as the prevention of child abuse and neglect, preventable medical problems such as failure to thrive and prevention of later school failure through early intervention. On-going developmental models may work to strengthen a family's ability to cope, identify individual strengths and weaknesses and design and implement a program to capitalize on a specific family's strengths. Crisis intervention models deal with emergent problems such as currently occurring child abuse and neglect, emergent health problems, domestic violence, drug and alcohol crises and economic issues such as homelessness. Some programs combine elements of all models. Depending upon the model, home visitors may adopt a teaching role, a therapeutic role, a support role, a referral role, a helper role, or in some cases, a punitive role. Some home visitors combine parts of several roles.

Program models of home visiting vary from occasional short home visits to home visits lasting several hours for several times each week. Program lengths vary from one visit to several months of visits to three to five years in duration. In addition, other services are often provided to the family by the program or in combination with other programs. A Home-Based Head Start program, for example, might assign one home visitor to eleven families for a nine-month period. Each family would be visited once each week for 90 minutes. During that 90 minutes, time would be spent directly with the parent by cooperatively investigating a subject chosen by the parent. Time might also be spent on a parent-child activity during which time the parent would take the role of teacher with her/his child. In addition to home visits, the family might participate in weekly parenting skills classes, weekly group socialization experiences for the children and monthly family-focused field trips.

A model of neonatal home visiting was pioneered by the Hawaii Family Stress Center in the 1970s and institutionalized by the Hawaii Department of Health in the 1980s. Known in Hawaii as Healthy Start (and across the United States as Healthy Families America,) this program assigns 15 families of newborns to one home visitor, known as a Family Support Worker, for a period of up to five years. Each family is visited each week for approximately one hour. As the family progresses, usually after 14 to 24 months, intensity of visits may decrease to every other week, once a month and finally once per quarter. During each visit, emphasis is placed on positive parent-child interaction. Bonding with their new baby is considered to be of primary importance, particularly during the early months. In addition, home visitors work to enhance family functioning by building trust, teaching problem-solving skills and helping parents identify positive supports in their lives. Home visitors also focus on healthy child growth and development. Transportation to medical and other appointments may be provided, the family may attend parent support groups or parenting classes, and will be referred as needed to other services.

The above descriptions of home visit programs are only two examples within a wide variety of potential program options.

Virtually every service provided to families can be provided through a home visit model if the program is willing to be innovative and open to change. Home visiting, by its very nature, requires that staff respect families and their living situations. Going to families' "turf" rather than expecting them to come to the agency often requires a radical change in belief systems - both of the agency philosophy and its staff's personal beliefs. Most of us grew up assuming that one visits agencies to gain access to services. From kindergarten through college and beyond, most of us went to school, to medical practitioners and to other services. We have been conditioned to believe that we, as consumers, clients or patients must go to the professional at the professional's pleasure. Some home visit programs have failed because staff have attempted to transplant traditional programs and services into the home, rather than developing programs and services specific to home and family.

The Stuart Foundations and The Haigh-Scatena Foundation chose The California Consortium to Prevent Child Abuse as the site of a one-year project to survey and review home visit programs in California in order to begin to broadly define what characterizes quality in home visiting programs. In discussions with Dr. Deborah Daro (Director of Research for The National Committee to Prevent Child Abuse and Principal Investigator for one of two current research projects on the Hawaii Healthy Start model,) it became clear that a one-year review could not define all standards and practices. Based on questions currently being asked across the country regarding home visit programs, it was determined that three principal areas of interest are: How do quality home visit programs engage families and keep them engaged? How do quality home visit programs set goals with or for families? How do quality programs provide supervision? These three areas are considered to significantly affect quality of services to families. By answering these questions (which in fact overlap into other areas of competency for home visit programs,) we are able to begin to develop guidelines for programs, agencies and foundations to consider when developing or enhancing family-focused home visit programs.

Twenty home visit programs were selected from across the state to participate in the Standards and Best Practices review project. Programs were selected from applications solicited from the fields of child abuse prevention, education, health, mental health and social services. The programs selected represent a wide variety of home visiting models and populations served. Programs were also located in a variety of agencies. Some programs target specific populations (i.e. American Indian teen mothers, recent Latin American or Asian immigrants, low-income parents, etc.) However, the majority of programs served a variety of cultures, ethnicities and populations, with the main similarity between programs being a focus on families considered to be "high-risk," "at-risk," or "high-need, low-resource" - all as defined by the local programs.

Two Home-Based Head Start programs, both located in community action agencies, provided a look at a long-established education-based preschool model with comprehensive services for the entire family. Two hospital-based programs, one health department-based program and three Indian Health clinic-based programs helped us look at the effects of holding services within an established medical home. Four programs receiving their referrals as a result of hospital births provided us with comparative information to Hawaii's Healthy Start model (Healthy Families America.) Three American Indian health clinic-based programs begin services pre-natally - an option also used by two social service agencies.

Many programs receive referrals from a variety of services, including medical clinics, child protective services, family preservation services, schools, mental health clinics and other sources.

Most programs are limited in the number of families they can serve, although one program is serving every family with a newborn in the entire (small) county.

Thirteen programs use paid home visitors exclusively, four programs use volunteer home visitors exclusively and three use volunteers and paid home visitors. The length of programs surveyed ranged from two months to five years. The intensity of services ranged from one home visit per month to at least one home visit per week. The majority of programs provided one home visit per week, at least at the beginning of services.

Many other services were provided to families in home visiting programs, including transportation, child care, parent support groups, crisis intervention, parenting classes, infant classes, counseling, advocacy, and family self-sufficiency programs. While some programs were trying to provide all other services out of their own agency, the majority of programs cooperated with other community agencies to build a comprehensive array of services for families.

Programs selected for the survey and review were divided into two groups: Mentor Programs and Developing Programs. Mentor Programs were defined as home visit programs that had been operating and refining services over several years. Developing Programs were just beginning or beginning again after a period without home visit services. The initial premise was to collect information on standards and practices from the Mentor Programs and use the information in helping the Developing Programs begin services, and this model was used. However, in addition, the Developing Programs provided a great deal of insight into standards and practices through the way they had conceived their new programs and we were able to offer some assistance to the Mentor Programs concerning long-range quality assurance.

This review project is important because the full potential of what quality means in home visiting is now being explored in detail. The need for progressive, interactive, on-going training and support seems clear. In order to provide such training and support, we must look to the front line workers themselves - the home visitors - for clues to optimal conditions. As a result of this review, we can identify some conditions under which home visitors seem to be most successful in helping families. We will then be able to more effectively develop and provide training that will measure and evaluate programs and their effectiveness with families.

"I WOULD LIKE TO SEE A MORE BROAD SPECTRUM OF PROGRAMS PUT INTO PLACE... AND, ALONG WITH IT ALL, THERE IS THAT SUPPORT FOR THE FAMILY, IT'S NOT JUST FOR THE CHILD... WE'VE GOT TO FOCUS ON THE FAMILY, WE'VE GOT TO NURTURE THE MOM TOO..."

Home Visitor

CHAPTER 2

LITERATURE REVIEW

In the United States, home visiting began with the Charity Organization Society, the precursor of modern social work, in the last half of the 19th century. The Charity Organization Society (referred to as C.O.S.) employed "Friendly Visitors" who made the charity work concrete and who hoped to bring the classes together. In the January, 1989 issue of Social Casework, Betsy Ledbetter Hancock and Leroy H. Pelton describe early home visiting practices as stated by Mary Birtwell (advocate for home visiting) in 1895. She stated that no notes were to be taken in the presence of the family, and that an explanation was always to be given when calling on a family. Friendly Visitors seemed to have some difficulty in trying to accomplish two different functions - investigating and helping. This is an issue today as well; purposes and functions of home visits haven't always been conceptualized by programs in a way that relieves role conflict and role ambiguity.

In 1905, home visits began at Massachusetts General Hospital as a means of providing patient education. In 1906, visiting teachers came into being; they were almost always assigned to schools in socially or economically depressed sections of town. In 1909, as a result of the first White House Conference on Children, Hancock and Pelton tell us that mother's pensions were created for "deserving widows with dependent children." Home visits became a way to see who was moral and worthy and therefore deserving, and who was not. The helping aspects of home visits became obscured by the need for investigation. Hancock and Pelton describe Mary Richmond's 1917 book Social Diagnosis, in which she identified the investigative function of home visiting as being to report unhealthful aspects as arguments to further legislation to help families. Unfortunately, the welfare laws of the 1940s and 1950s, which deprived families with men in the home from receiving public assistance funds, made investigation on moral grounds even more pronounced.

In the March, 1983 issue of the Journal of Sociology and Social Welfare, Terry Holbrook notes that, in 1919, Richard Cabot wrote (in Social Work - the Doctor and Social Worker) that the role of social workers in the home was to "discover nests, foci, or hotbeds of disease." Smallpox, diphtheria and TB were still taking tens of thousands of lives each year. Social workers founds that they were more positively accepted into the homes if they were connected with a physician.

In the 1950s and 1960s, home visits decreased as social work's philosophical emphasis shifted from environmental factors to psychodynamic theory.

Home visiting has long been connected with parent education. In America's Family Support Programs, Lois Wandersman notes that the focus of the parent education movement shifted in the 1960s and 1970s from middle class self-improvement to the disadvantaged as the federal War on Poverty began. These programs demonstrated positive effects on mothers and children, but didn't erase educational or social inequality as some had hoped. In fact, some critics argued, these programs placed the blame for social and educational inequality on the victims (the disadvantaged.)

Hancock and Pelton write of Jane Addams' interest in home visiting. In 1915, writing about early home visits, she noted class problems in which the home visitor is surprised to find that the "safest platitude may be challenged. She refers quite naturally to the 'horrors of the saloon' and discovers

that the head of her visited family does not connect them with horrors at all. He remembers the kindnesses he has received there, the free lunch and treating which goes on, even when a man is out of work and not able to pay up, the loan of five dollars he got there when the charity visitor was miles away and he was threatened with eviction."

Moving away from Mary Richmond's ideas for strengthening legislation, home visiting by social workers increasingly focused on adjusting individuals to a realistic acceptance of their conditions - away from championing a cause in court or on the street and into searching for a cause in the home. In the March 1983 issue of Journal of Sociology and Social Welfare, Terry Holbrook writes that Richmond intended home visits to be used in a spirit of mutual trust and relationship, but they had become increasingly bureaucratic.

Today, as understanding of human development has increased, many programs that use home visits have shifted from a child-focused, blame-finding approach to a more family-focused view: looking at the family as a system which is part of a larger system of social network, neighborhood and larger community. In fact, home visiting seems to have returned to its original intentions that seek to bring classes closer together, not the emphasize the advantages of one over another. The question now is: what have we learned that can help us make home visiting more responsive to individuals and to the larger community?

The general reason why home visiting has been popular as a way of serving low income and high risk families seems to be that it represents a reaching out to families; it gives the home visitor a fuller appreciation of the environment and lends realism and relevance to demonstration and modeling by the home visitor. Methods of home visiting vary from program to program, from home visitor to home visitor, from family to family, and over time as needs and interests evolve. There seem to be certain activities that often happen on home visits. In the September 1987 issue of Zero to Three, Mary Kay Larner and Robert Halpern describe lay home visiting programs. They identify core activities as some combination of information sharing, modeling, demonstration, emotional support, joint problem solving, service brokerage and assistance in meeting needs. Even in cases of home visits for the purpose of investigating child abuse and neglect, some of these core activities are used.

Home visits give a greater appreciation for the daily environment of the family and many additional conscious and unconscious cues that can be used to strengthen the links between the home visitor and the family, which is seen as the unit of intervention. The July 1987 issue of CDF Reports states that Head Start was one of the earliest programs to try this family resource approach. Barbara Wolfe and Julia Herwig, in The Head Start Home Visitor Handbook (1986), list three elements they feel are basic in order to run an effective home-based program. These are: a whole-hearted staff commitment to the philosophy of **parents as partners**, effective information exchange, and interpersonal relationships.

The impact of personal values on home visiting is raised as an issue by Mary Claire Heffron and Jerry C. Jonnson in A Systematic Guide for Planning or Improving Your Family-Oriented Home-Based Program (1981). They write that a competent home visitor does not push her/his own values on the family, facilitates rather than problem solves, recognizes and magnifies family strengths and knows the limits of her/his own role. Sometimes the limits of the role are difficult to determine. In Psychological Reports (1982 #51) Frances M. Haemmerlie and Robert L. Montgomery found that home visitors often find themselves in role conflict due to the needs of families and the demands of the overall program as interpreted and evaluated by program staff.

Training in the area of personal and societal values is a need for home visitors. Being human beings, they bring all of their own positive and negative feelings about class, race and sex with them when they visit. Their own backgrounds may not have prepared them to deal with the diversity found in the homes they visit. They may find that they encounter value and class boundaries much more often than classroom staff or traditional social workers or counselors, who see clients on agency ground. Stefi Rubin and George S. Morrison suggest a shift in models to reduce some of the issues of personal and societal values, including how families are perceived by staff, supervising staff and consultants. In the July 1985 issue of Techniques, they recommend changing from a parent training model to a parent support model. A parent training model comes from assumptions of "ideal parents", tends to see parents as having deficiencies that need to be corrected by a home visitor, defines family needs for the family and gives priority to parent training. By contrast, a parent support model assumes that each family has its own abilities, needs and ambitions that can be supported in whatever way suits the family, encourages families to define their needs for themselves and gives priority to support services.

In this age of dwindling resources and increasing needs, concern for quality and the most effective use of resources becomes essential. Where do we start, when there is not enough money or resources to contain all problems and support all families? Deborah Daro, Director of Research for the National Committee to Prevent Child Abuse points out, in a 1989 working paper, that the U.S. Advisory Board on Child Abuse and Neglect believes family support services funding should be used for prevention programs aimed at families of infants and toddlers and recommends that an array of primary prevention services and supports, including home visiting, must be made available to all families. In this case, primary prevention means helping families before an incident of abuse or neglect occurs. The U.S. Advisory Board's report particularly emphasized the need for home visiting, which families use voluntarily rather than being forced to use, to be provided to all expectant and new parents.

Looking at successful models of home visiting in the research, particularly in engaging and setting goals with families, brings up the work of Wayman, Lynch and Hanson of San Francisco State University, referenced by Dr. Jeree Paul in Zero to Three (1989) who note that "successful family-professional partnerships are characterized by mutual respect, trust and open communications. Home visitors' effectiveness in establishing such relationships is influenced by their sensitivity to the cultural background of the families with whom they interact."

Whatever critical element for success and quality one looks at (from engaging families to setting goals to case load management,) supporting those critical elements comes back to appropriate clinical supervision of home visitors. Dr. Jeree Paul of San Francisco State University (in Zero to Three, 1994) describes supervision as follows: "Supervision exists to provide a respectful, understanding and thoughtful atmosphere where exchanges of information, thoughts and feelings about the things that arise around one's work can occur...Supervision is not intended to produce a clone of the supervisor. It is instead designed for the mutual discovery within the process of supervision of the relevant characteristics and skills for these unique supervisees. In the process, they will learn how best to use themselves in relationship to those to whom they will provide their services. Supervision well done equally enlarges and teaches the supervisee. Not only in the ways just described, but also because the supervisor re-experiences her own professional growth and is very often markedly re-inspired by the supervisee's enthusiasm for the work." In Home Visiting (1990), Barbara Wasik adds that "in addition to being critical for morale, supervision has also been described as essential for maintaining objectivity and professional competence (Hardy-Brown, Miller, Dean, Carrasco & Thompson 1987.)" In the case of research programs, such as Wasik's Infant Health and Development Program, she notes that supervision also served to prevent

"program drift- a situation in which individuals tend to drift away from the specified objectives and goals."

Summing up the past thirty years in 1991, the United States General Accounting Office (G.A.O.) pointed out that thirty years ago, Dr. Henry Kempe identified the battered child syndrome; twenty years ago research was begun that proved high-risk families could be identified in the perinatal period. Fifteen years ago, lay home visitors were shown to be an effective way to prevent child abuse and neglect; seventeen years ago the federal government began funding demonstration projects to test various ways of preventing and treating child abuse and neglect and the most effective projects funded used home visitors to work with families. The G.A.O. Board called upon the federal government to begin immediate planning for universal voluntary neonatal home visitor services.

Until there are more resources available (or less families in need) most communities will continue to have a need to prioritize not only services, but which families will receive those services. With prioritizing comes the obligation to chose the most effective model that can support true internal change in the most possible families. History has taught us lessons about how not to serve families; now our task is to provide quality, long-term services that will ensure enhanced family functioning, healthy child growth and development and support parents and children in their interactions with each other. This report looks specifically at three areas that are critical to providing quality services to families in their own homes.

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"I LOOK FORWARD TO EACH VISIT -
WHAT'S GOING TO HAPPEN THIS TIME?"

Home Visitor

CHAPTER 3

BEST PRACTICES

There are many kinds of home visit programs. There are family preservation and reunification programs, family reconciliation programs, there is home-based Head Start, there are Healthy Families programs based on Hawaii's Healthy Start model. There are long-term programs, short-term programs and in-between programs, There are nursing models, social service models, educational models and mental health models. However, in looking across the spectrum of home visiting, there seem to be some things that work across models and kinds of programs. Some of these things are:

* voluntary participation by families (people seem to be more willing to participate when they are able to initiate their own changes.)
* addressing families' multiple interrelated needs comprehensively (making sure that the program comprehensively meets families' needs and is not set up just to meet agency needs - sometimes this means that a program will be more complex or require more staff time per family in order to provide a quality service than the program had originally envisioned.)
* developing parenting skills. (never forgetting the importance of the parent-child relationship no matter how many concrete social service, health and education needs are also seen.)
* providing nurturing connections with others in similar situations (breaking that isolation)
* responding to individual and community needs (both in terms of program time limits and in terms of individualized and emergent program curriculums.)
* working to prevent future crises (building trust, strengthening the parent-child bond and encouraging problem-solving skills right from the beginning.)
* coordinating and cooperating with other agencies (one agency doesn't have to 'do it all.')
* respecting individual and cultural differences. (celebrating differences as well as similarities.)

In my original research in 1990, I interviewed a wide variety of home visitors regarding best practices in home intervention programs. I combined their thoughts with my research in the following list:

* building trust is the first priority.
* listen more than you talk.
* give choices whenever possible.
* provide individualized services within the context of your program structure.
* concentrate on family strengths.
* never forget who is that parent of the child.
* support and validate home visitors in both successes and failures.
* remember that home visitors tie their success with a family to their ability to build trust with that family and tie their failures to their inability to have built trust with a family.

ENGAGING FAMILIES

During the past year, I have specifically looked at several critical elements with twenty home visit programs. In investigating how quality programs initially engage families and keep them engaged over time, I found most project programs to share the same basic philosophy of working with families. A supervisor at the Healthy Families Ventura Cooperative pointed out that engagement

begins with the quality of the staff - the process of engagement really starts in their recruitment process. The crucial home visitor abilities to build trust, display warmth, appropriately self-disclose, empower families rather than building dependence, accept families where they are and believe that all families have strengths were echoed in the comments from home visitors across the many programs visited. Home-Based Head Start home visitors noted that they learn right along with the families they visit and one home visitor remarked that sometimes she feels like she's a part of a miracle.

Across most programs, there was a general shared belief that less telling families (what to do) is better - home visitors cite the need to believe that families can make progress themselves and sometimes just need a little boost to be successful. Most successful home visitors see themselves as flexible and treating families the way they would like to be treated - empowering them with a level of respect. One home visitor described herself as a feather: she goes in like a feather, lightly, with the concept of people helping people. Quality programs tend to share certain methods in early weeks of visiting families. While most successful programs have moved away from providing concrete goods on a regular basis to families (thus building dependence on the program in the family,) many programs do note that the process of engagement often begins by meeting a concrete need. Good home visitors know that building trust takes time and can't be rushed. Strengthening a family's ability to problem-solve in order to provide for their own concrete needs also takes time. In the meantime, helping to meet a concrete need seems to help allay a family's initial concerns about the program, particularly when the home visitor is careful to explain the overall program philosophy of supporting families in providing for their own needs. Programs that are not careful to distinguish between directly meeting an occasional concrete need and strengthening families to meet their own needs versus directly meeting families concrete needs throughout the length of the program run the risk of encouraging program dependence by the families and of confusing and disappointing families who mistakenly believe that the program will continue to directly provide for all needs.

In quality programs, first interactions with families usually involve a lot of listening and "talking story" with families. Home visitors must be aware that they may encounter the wrath of the family toward the "system" in early visits and must believe in the necessity to be persistent - to "hang in there" with the family, no matter what the situation. One home visitor shared her philosophy of enthusiasm as helping her engage families from the beginning. She is careful to use key words and phrases such as "I'd LOVE to come out and see you and your baby. I'm REALLY EXCITED to come out and see you." Making families feel special, giving them sincere compliments works in home visiting just as it does in life. Young mothers have told their home visitors that, in the past, they always felt invisible and beaten down. Observing the social amenities and being enthusiastic about the families they serve allows home visitors to begin to engage and build trust.

Being consistent is important in engaging families and keeping them engaged over time. A home visitor noted that engaging families over the long run involved "the CONSISTENCY of being there every week - it;s just knowing you're there, that you're going to be there every week." If a home visitor offers to locate a resource or provide materials or make a phone call or come back later the same week, she or he must follow through on that promise. Many families have been disappointed and disillusioned by others in their lives, and perhaps by other programs or systems. Home visitors build trust and cooperation by always following through on their promises. This speaks to the need for home visitors to know their limits and their program limits. It also speaks to program length - we know consistency builds trust and strengthens the family's willingness to participate and take risks in changing. Like trust, building consistency takes time - often a great deal of time. When home visiting programs offer short-term services, families are just beginning to trust that the home visitor will be there for them when services end.

Even when programs transition families to another service, such as a volunteer follow-up component or center-based services, consistency and trust are compromised. Engaging families by building consistency and trust takes time - time spent one-on-one with the home visitor. Only after the family has learned to trust the home visitor and make plans with her or him can the family then move outward into attempting trust with groups and center-based activities. Attempting to move the family toward center-based services and less-intensive options too soon will decrease the quality of the home visiting experience, dilute the learning taking place in the home and, in fact, change the orientation of the program from a home visiting program to a center-based program with home visiting.

Overall, project programs demonstrated quality engagement methods by providing for immediate concrete needs at the beginning, being consistent, following through, being clear about program goals and limits at the start, showing enthusiasm for the program and for the family from the first visit and giving families time to trust and engage. Exceptional programs also shared a philosophy of believing from day one in the importance of positive parent-child interaction - as one home visitor put it "even during a crisis, bring it back to the baby. Say 'even with all this going on, your baby looks really secure with you - I can tell from the way you're holding her.'"

SETTING GOALS

In most established home visiting programs, setting goals with families has evolved over the years from home visitor or staff-driven decisions to family-driven decisions. Quality home visiting programs have learned to distinguish between program goals that must be addressed in order to keep program funding (i.e. 100% immunization of program children) versus family-led goals which lead to enhanced family functioning as families learn to determine their own needs and address them. Many of the programs in this project shared a strong philosophy around guiding families to set their own goals. This does not mean that the home visitor or program has no input into what the goals might be. Experienced home visitors suggest some goal areas if parents don't see a need. For example, teen home visitor programs usually make sure that goals around school attendance or graduation are addressed. Experienced home visitors also understand the need to make goals time-limited, realistic and achievable and not focused around crises.

In order to help families set goals, home visitors must understand goals and the goal-setting process. Project programs had varying levels of understanding and training regarding making goals concrete and helping parents (and staff) think of goals in a positive, non-threatened manner. One home visitor with a good deal of experience had learned to ask herself "will this goal help (the family) to solve their problems? Will this help them improve their family support?" Considering those questions can help the home visitor structure discussions and supportive questions toward the family without becoming negative toward the family's initial thoughts regarding their own goals.

Goals will be different for different families depending on the family's culture, religion, socio-economic status, individual concerns and previous involvement or lack of involvement with other social services, health, mental health or education systems. When community workers are used as home visitors, the chances increase that the home visitor will understand certain goals based on the family's culture, ethnicity, religion or socio-economic level and will be able to support the family with such family-specific goals. Speaking the same language, understanding some of the same cultural traditions and experiences can be a strong bonding experience when setting goals with families. Home visitors who do not share similar experiences must be sure to participate in on-going values clarification, multi-cultural and anti-bias trainings and experiences. Even

community workers will not have the same experiences as all the families on their caseloads. Choosing home visitors who are accepting of persons different from themselves helps the program along the path toward truly supporting all families. Home visitors in several programs pointed out the need, particularly in health-related issues, to learn to weave the families' cultural traditions and practices and modern medicine together. Such a weaving can be difficult and time-consuming, but underscores the importance of both respect for the family and information sharing with the family.

Most programs understood the need for home visitors (as the main conduit of information to the family) to set goals with the family. Understanding the goal-setting process and learning to set goals with families are issues that require a strong and on-going staff training program and a commitment to allowing families to try (and perhaps not succeed on the first attempt) to problem-solve around their own issues.

SUPERVISION

As this project unfolded, it became clear that supervision was a key point in determining the success of programs regarding family outcomes and satisfaction of staff or volunteers. The "short answer" to what we found across programs is that, for the most part, programs are not providing enough and timely-enough clinical supervision for staff and volunteers. However, the "long answer" showed that programs believed in the need for supervision but usually had not clearly thought through how much was enough and in particular, had not recently visited research and training books and articles for guidance. Often, decisions regarding how much supervision to provide were based on budgetary constraints or on a feeling that staff or volunteers did not want more supervision. In fact, we found just the opposite. When home visitors were asked what they would like for their program, we found home visitors from a number of programs asking for more supervision. It was heartening to hear the actual front-line workers acknowledging their need for regular feedback from supervisors with more experience and education.

An outstanding home visit program in this project, which provides frequent and on-going supervision, noted that supervision brings the worker back to "why they are doing what they are doing" This program pointed out the need to make sure that home visitors feel confident about being able to do their job with families - making sure that home visitors don't mirror the panic they may see in a family. A home visitor in this program noted that one thing that keeps her going in her difficult job is "working with others who share your concerns and knowing that the supervisors really care about you." Her supervisor noted that "you don't see the world in the same way (once you've done this kind of work.) You look at people and realize that there are differences and its OK."

A number of supervisors had thoughtful insights about the reason for supervision. One supervisor talked about supervision as a lifeline to the family and saw it as critical in giving the home visitor a "language" to describe her experiences in the home. This supervisor also noted that supervision can help home visitors see small gains in families and celebrate those gains. More than one supervisor pointed out the need to use supervision to help home visitors understand boundary issues, which tended to crop up in every program visited. In fact, boundary issues are perhaps the most important reason for frequent and on-going one-on-one clinical supervision. Supervisors talked about the need to tailor supervision to meet staff's individual needs - a process which may not always be comfortable. A Head Start supervisor and home visitor talked about supervision as a continual feedback process which leads the home visitor to find solutions or answers.

Seeing supervision as an opportunity to nurture professional development helps one supervisor continue to provide frequent supervision. Understanding that they also get a lot out of the process helps supervisors as they struggle to prioritize their busy schedules. Both in this project and across the country, the most successful programs see supervision as team work, with the supervisor (sometimes called the case manager) and the home visitor as a team with the family and working on behalf of the family to support them in their growth.

OTHER

Other quality areas observed among project programs included a commitment to an emergent curriculum approach. Supervisors and home visitors alike noted the need to not become too focused on tasks. Insisting on finishing the lesson plan at the expense of the family's immediate concerns leads to a lack of trust on the part of families and to home visitors being seen as rigid and teaching-oriented, rather than flexible and facilitating. A program manager described her program as providing "client satisfaction." She mentioned families having someone to talk to - a support person, someone there to show the family about infant care, to explain how to do infant care, to help families access additional services that they have not been able to, and someone to also address the mothers' needs. This emergent curriculum approach to services highlights the need to be cautious about using "canned curriculums" in which every home visitor does the same task with every family on the same week. While the canned curriculum approach makes home visit planning easy for home visitors, it does so at the expense of family individuality. If a program choses to use such a curriculum, it must address the quality concern regarding what a home visitor is to do if a family is in crisis and cannot complete the assigned task that week.

Several programs spoke to the need for home visitors to carry small caseloads. Even among programs whose home visitors carried higher or more difficult caseloads than is desirable, the supervisors spoke to their wish for home visitors to have appropriate caseloads. Unfortunately, tight budgets and high required program numbers from funding sources have often driven programs to sacrifice appropriate caseloads in order to secure funding. The quality concern, of course, is that some programs are feeling pressured into this no-win situation.

Home visitors often noted the need for peer support. Most supervisors also saw that need and responded to it by providing group supervision and training times for home visitors to come together and share. Quality programs also tend to have times (for example, the first hour of the day,) when home visitors can share and support each other before starting on their home visits for that day or week. Just knowing that others are doing the same job and struggling with the same concerns makes a big difference to home visitors and whether they continue in the field. A number of home visitors asked us for a way for them to come together on a regular basis as peers and for training opportunities.

A number of programs looked at home visiting as a service necessary for all families - not because they are in crisis, but because, as the co-founder of Newborn Connections put it, "everyone needs support to peacefully parent children 24 hours a day - home visiting is a necessity, not a luxury." Finally, the founder of W.E.E. C.A.R.E. in Placerville, CA summed up quality home visiting programs as follows: "Infants need highly attentive caregivers; caregivers need highly supportive attention; and people of good will can provide that support."

"AS LONG AS SHE STAYED DYSFUNCTIONAL,
SHE GOT LOTS OF SUPPORT AND VISITS.
(IT'S) A REAL PROBLEM -
WHEN PEOPLE GET HEALTHY,
BECAUSE OF NUMBERS,
WE HAVE TO WITHDRAW SERVICES...
IT'S KIND OF A MIXED MESSAGE
THAT WE GIVE THEM..."

Home Visitor

CHAPTER 4

PRACTICES NEEDING REVIEW

Home Visitors face many issues in working with other agencies, other social services and health professionals and the community in general. Problems, such as public attitudes about racism, sexism and classism, can limit home visitors' access to resources. Lack of cooperation from other agencies, lack of community resources for certain groups of people and lack of understanding about the functions and accomplishments of home visiting are some of the ways that public attitudes are expressed.

There are also many issues around working in one's own agency. If agency and program protocols are not clear, home visitors find it hard to be consistent in the homes they visit. If agency and program goals and objectives do not match, home visitors and their supervisors get caught in the middle. If funding constraints require large caseloads and little supervisory time, home visitors (and their supervisors) move quickly toward "burn-out." If home visitors are not supported, or feel like 'step-children" in their agency, the program becomes seen as less important and requiring less resources.

In addition to dealing with others internally and externally, home visitors are human and must deal with their own issues. Mixed messages, meeting personal needs through the families they serve, attempting to rescue families, expecting gratitude and personal attitudes about race, class and sex are some of the issues that home visitors must confront in themselves in order to effectively work with diverse populations. The home visitors we interviewed recognized some of the above issues - and articulated some of them.

ENGAGING FAMILIES

As pointed out in "best practices," engagement really starts from the time a program begins its hiring process. The best indicators of success in home visit programs are the home visitors. It becomes a practice needing review when programs do not look at all sides of the issue when deciding what type of home visitor to hire. For example, programs who chose workers based on the workers' skills and experience (rather than choosing paraprofessional community workers) may find home visitors who understand systems and concepts of change, but may not have the personal characteristics and similar backgrounds that encourage trust building and acceptance of a family's current situation. On the other hand, programs who chose to hire paraprofessional community workers based on personal characteristics may not always remember that those community workers then need a lot of initial training, on-going support and supervision to build their skills. They cannot be expected to provide the same level of interventions from the beginning as professional workers .

Some programs seem to have not thought the hiring process through completely. In addition, some programs experience a change in what type of persons are hired when they change supervisors or managers. This can lead to a program in conflict with itself as newer workers come in and work beside very different long-time workers. In some situations, hiring preferences seemed to be made based on the supervisor's or manager's past personal experiences (with paraprofessionals or professionals) rather than on a recent review of the literature or of the model being used. This was particularly true if the manager or supervisor was a professional who had had a negative personal experience with a paraprofessional in a previous agency or position. This points to the need for on-going anti-bias training, particularly in the area of class. It takes more than a warm, caring person to build a competent home visitor, but without the warmth and caring, programs have

workers who lack the ability to truly engage. Since engagement starts through hiring the appropriate home visitors, this brings up the issue of supervisors and managers examining their own beliefs and the program's beliefs about who can do the work.

SETTING GOALS

In the majority of programs surveyed, goal setting is considered important and a positive step for staff and families. Unfortunately, when interviewing home visitors, it became apparent that many home visitors (professional and paraprofessional) do not thoroughly understand the process of goal setting and introducing goal setting to overburdened families. It is clear that breaking down the process of goal setting must be made a more integral part of training and supervision so that home visitors will understand it well enough to make the process non-threatening to families. Part of understanding the goal-setting process is learning to make goals achievable. We noted that some programs which visit over a relatively short period of time set goals with families that seem more appropriate for long-term programs. While it is understandable that home visitors and supervisors want to help families with all their concerns and problems, shorter-term programs should learn to moderate their goals and objectives based on their timelines. If families' needs require goals that are complex and long-lasting, we question whether they should be enrolled in a short-term program. In most cases, we would recommend that they be referred to a long-term program to avoid terminating them from the program with their goals unmet - yet another disappointment for overburdened families who have not had much success in their lives.

In a number of programs, goal setting is required to be done very early on - in fact on the first or second home visit. While this practice may produce paperwork necessary to the family file, it does so at the expense of building trust and respecting families' differing needs for time. Goals set early on also reflect program goals to a greater extent and family goals to a much lesser extent. We also visited programs in which families were brought in to the center to see the supervisors who oversaw and clearly guided the goals set for the family. This would seem to create somewhat of a paradox since home visitors are introduced to the family as their main supporters and guides. We wonder whether this practice has to do with supervisors being professionals and home visitors being largely paraprofessionals - again the issue of clearly looking at one's own beliefs and the program's beliefs about who can do the work.

SUPERVISION

All the home visitors in all the programs reviewed received "supervision", but that supervision varied from a high of weekly clinical supervision plus group supervision to a low of one group meeting per quarter for training by a supervisor. A number of supervisors expressed concern that their home visitors (volunteers and paid) would not attend additional supervision. They shared their concern over the fact that they feel they can't ask staff (volunteers in particular) to commit to frequent supervision, which the supervisors see as an additional time commitment. We suggest that, rather than an additional time commitment, frequent supervision is an integral and critical part of required hours, whether they be paid or volunteer.

Home visitors are directly intervening in families' lives - and without frequent, appropriate supervision, they have the potential to do great harm to families who are already overburdened. In these days of increasing stressors on families and decreasing resources, being a "friend" is not enough. When families are assigned a home visitor, that worker needs to stay aware of potential signs of abuse, neglect, substance abuse issues, family violence, mental illness, boundary issues and many other areas. Without frequent supervision from professional supervisors, the burden of

"professional assessment" lies on the home visitor, who often is a paraprofessional or professional without significant work experience.

With infrequent supervision based on perceived staff needs, we have a great deal of concern over the potential for a philosophical conflict between family needs and staff needs. Who is the receiver of services? What is the reason for the program existing? How can the program develop its culture so that the needs of the family drive all aspects of the program model and are considered first and foremost? In fact, when talking to home visitors, we found that many of them wished for more supervision on a more regular basis. Most home visitors had concerns about missing or misinterpreting critical information and saw supervision as a way to check out their observations in order to provide appropriate services to families.

Some programs use a model of "as-needed" supervision which assumes that the home visitor will seek out the supervisor, and be able to access time with her or him, when needed. While as-needed supervision is an important part of supervision, it does not take the place of regularly scheduled, frequent individual, clinical supervision. The use of as-needed supervision as the predominant method of supervision encourages a crisis-oriented and reactionary model of program design and runs the risk of what Barbara Wasik refers to as "program drift and high staff burn-out" in her 1990 book, Home Visiting. When a home visitor responds to crises all the time, it negates the value of goal setting for families and runs the risk of families who do not present as being in frequent crises falling through the cracks.

In order to provide appropriate supervision, supervisors must have the support of the program managers, directors and agency administrators. This can be difficult if those persons do not clearly understand the goals and objectives of home visiting programs. If an agency is running mostly center-based programs, it will not necessarily grasp the concept of one-on-one supervisory team work on behalf of home visited families. Before an agency takes on a home visiting program, it must be committed to the differences involved in this approach and willing to give supervisors the time they need to supervise. Agencies that assign supervisors to many different programs run the risk of the home visiting program evolving on its own, without becoming part of the agency culture.

OTHER

CASELOADS: This review highlighted a concern that unrealistic program and funding source goals for numbers of families to be served leads programs to convert their program models to serve more families (a "numbers mentality" rather than a "quality of service mentality.") Some supervisors and managers also feel that "their home visitors" can handle higher caseloads because of their substantial work experience or education. While this may be so, we argue that researching the chosen model and its reasons for a particular caseload are more important than whether workers can actually handle more cases in a given week. We believe that serving fewer families with quality and following the program model is more important than serving more families with a consequently limited budget. This leads to diffusement of quality and a sense of overload and encourages a crisis-reaction method of service.

LENGTH OF SERVICE: We share a great concern over artificial time lines in programs, a practice almost always based on the "numbers mentality." Programs were visited in which families were all dropped in intensity of service after several months, whether the family was ready for less service or not. Given the time needed to build trust with families and the time involved for true, internal change, one questions whether change taking place in such programs might be

predominately external change, possibly reverting back once the home visitor is not longer visiting on a frequent basis. The Healthy Start model of Hawaii Family Stress Center has shown over the years the importance of on-going case review in order to individualize for each family and provide services as long as that family needs services and as intensively as that family needs at that time. If a program chooses a short-term program with time limits for families, that program must look closely at its goals and objectives and not base them on successes occurring in longer-term, individualized programs. Short-term, time-limited home visit programs must not assume, even with very competent home visitors, that they can effect long-term change. They must look more clearly at what can be accomplished in the short-term - usually meeting some concrete needs, not psycho-social change. In addition, because many families chosen for home visit programs are very isolated, short-term programs must weigh the pros and cons of engaging families, then dropping them.

BOUNDARIES: We were surprised to find programs in which home visitors are still giving their home phone numbers to families. This may be possible if it is something like a Doula Program, where the object is to attend prenatal classes together and act as the coach in the delivery room. However, this practice is very much a concern when it involves giving personal phone numbers out to families with whom one has a helping relationship, particularly if that family is overburdened, or at-risk in some area. This brings up a great concern that some programs are not adequately addressing boundary issues between staff (whether volunteer or paid) and families. Even volunteer home visitors have a responsibility to remember the differences between them and the families they serve. No matter how close they may feel to that family, they are still the helper and the family is still the receiver of service. This is, by definition, an unequal relationship, with the power always being on the side of the helper. Persons with power must always be careful to not abuse the relationship - allowing a family to think that a relationship is more than it actually is leads to abuse when the family asks for more than the home visitor can give and the home visitor has to remind the family of the differences in their relationship. The bottom line is that, even with community workers who come from similar backgrounds (and even more so when the visitors are from different socio-economic backgrounds,) home visitors are not merely "friends" - they may be friendly and enjoy a good working relationship with the family, but they are acting on behalf of an agency or program.

TRAINING AND TECHNICAL ASSISTANCE: In the past, the majority of the home visiting field has tended to focus program training around indicators of abuse, the disease model, treatment-focused needs and meeting concrete needs. There is a need for home visitor training in child development, parent-child interaction, health, nutrition, appropriate advocacy and goal setting.
Some of the reviewed programs were accomplishing all of these training needs, others were still focusing more narrowly. A concern is that, even in programs with narrowly defined goals, home visitors and supervisors need a wealth of training in order to prevent over-emphasizing certain problems or conditions. For example. home visitors and supervisors in child abuse programs need some training in child development so that they will not confuse appropriate developmental levels with parent-child bonding and separation problems. This becomes particularly true if a child has been removed from its home for any period of time. In order to be able to stay positive with families, home visitors and supervisors need to be understand something about the processes that occur during crises.

Some programs provide fairly comprehensive pre-service training. This is very important training and must not be neglected. In addition, more programs should provide regular, on-going training that continues throughout the life of the program. Developing a comprehensive, component approach to services (expanding on the Head Start model) provides a structure in which all

components (social services, health, education, parent involvement, mental health, nutrition, administration, training and technical assistance, etc.) are addressed as important parts of the comprehensive program. More programs need to make budget commitments to training and technical assistance - it must not be an add-on but rather be built in as an integral program component (again, expanding on the Head Start model.)

The home visitors and supervisors in the visited programs tended to be extremely dedicated workers who care deeply about the lives of the families with whom they work. Degrees of knowledge, understanding and empathy vary widely, as is the case in all professions. In home visiting programs, however, these issues become increasingly important due to the nature of the job; going into families' homes and working on difficult, intense subjects such as child abuse and neglect, family violence, substance abuse and lack of resources. The detachment of the office or classroom is not there. Home visitors are in the middle of whatever is happening at the moment. There is a sense of reality that cannot occur on the professional's turf. As a result of interviewing the twenty home visit programs, I have constructed a summary, recommendations, and a broad base for training and curriculum guidelines. This model or base is general and does not include training on individual programs or the "how-to"s of home visiting. Future projects will include training outlines specifically for the three critical areas of engaging families, setting goals with families and supervision.

"WE'RE GOING THROUGH IT TOGETHER...

SHE IDENTIFIES WITH ME...

SHE HAS SUCH AN INTUITIVE, SENSITIVE HEART."

Parent

CHAPTER 5

SUMMARY

Many of today's families face overwhelming problems. Inadequate access to health care, lack of affordable housing, inadequate income to meet family needs and lack of accessible and affordable resources are serious concerns. Each community needs a broad constellation of services available to families of all kinds. Such a broad constellation must include primary prevention services such as community education, primary and early intervention services such as parenting support groups, Healthy Families America programs and well child clinics, secondary and tertiary prevention programs such as family preservation services, and treatment programs for families who are suffering. Home visit services often act as a first step into the family, allowing trust to be built so that overburdened families can strengthen themselves and re-enter their community. Home visit programs have shown many positive impacts. Among those are:

HEALTH:
* early and consistent prenatal care for pregnancies occurring after the family has become part of the home visiting program.
* attachment to a medical clinic or doctor by the family.
* completed immunizations and well-baby care.
* less use of the emergency room and tobacco use among home visited parents.

FAMILY FUNCTIONING:
* more involvement of fathers in the parenting process.
* reduction of subsequent pregnancies.
* better planning of subsequent pregnancies.
* appropriate use of community resources.
* use of community services to obtain job training and financial stability.
* higher levels of school completion, especially for adolescent parents.

CHILD ABUSE AND NEGLECT:
* increased knowledge in parents of "ages and stages," (child development, care, management.)
* improved parenting and discipline skills.
* better use of positive family support systems.
* increased positive parent-child interactions.

SCHOOL READINESS:
* more consistent and appropriate stimulation by parents.
* increased interest in children's developmental stages.
* sense of trust and communication skills in children.

In Within Our Reach, Lisbeth Schorr states that effective services " are particularly important at periods in the life cycle when families are both vulnerable and unusually receptive to new learning. In the time surrounding pregnancy and birth, for example, good help can be instrumental in getting the relationship between infant and parent off to a good start." She asks: "now that we know how to prevent damage before it occurs, does it really make sense to withhold services until children or their families exhibit clear signs of pathology?"

The home visit programs surveyed in the Standards and Best Practices project varied in length of program and intensity. However, we can conclude that even programs with shorter lengths and less intensity were attempting to impact serious and complex family problems. Even programs referring to themselves as serving low to medium risk families were dealing with issues of domestic violence, child abuse and neglect, substance abuse and other complicated matters. This becomes a serious issue when considering training for supervision and all it entails - from selecting home visitors to assigning caseloads to coaching home visitors on engaging and setting goals.

Barbara Wasik's 1994 survey of home visiting programs for families with abused and neglected children found that the largest percentage of programs providing services identify themselves as private social service agencies with the intensity and frequency of home visits varying as a function of case load. The services that most programs reported as their most important priority were closely matched to "recommendations made by many in the field for a focus on parent coping and parenting skills. Knowledge of child development and stress reduction have also been viewed as important components of (such) programs...These highest priority services are also consistent with research studies showing that parents who are abusive and neglectful are not as competent in everyday problem solving skills as non-maltreating parents."

This survey found a similar focus in most programs. In particular, programs seem to be moving toward an emphasis on parenting skills. Some outstanding programs have moved beyond just offering parenting skills information and practice toward a focus on encouraging positive parent-child interaction. These programs recognize that, when the program is over and the home visitor has said good-bye, a positive relationship developed between the parent and child will be the best predictor of future family relationships. It is not enough to just offer parenting skills tips such as alternative ways of disciplining. While such skills are useful and helpful to parents, if the basic relationship between parent and child is not grounded in an understanding of child development and relationship building, all the parenting tips in the world will not ensure that the child will grow up in an accepting and nurturing home.

Most programs in this survey are quite successful in engaging families. Meeting a few early concrete needs, appropriate self-disclosure, spending time listening and "talking story" are techniques seen over and over among the programs. Home visitors tend to enter homes with positive attitudes toward families and believe in focusing on strengths. They are eager to share information that they have accumulated and most see themselves as facilitators or helpers rather than "experts." When home visitors in particular programs saw themselves as the "experts" and attempted to screen families and "diagnose" them by themselves, they were much less successful. Programs who saw themselves in this manner, in fact, had difficulty in engaging and retraining families.

Overall, programs had more success in initially engaging families than in keeping families engaged. Most programs could benefit from taking a look at engagement over time, with an emphasis on why families drift away and what to do when this occurs. The Hawaii Family Stress Center's Healthy Start program offers a model for working with parents who have disengaged due to a crisis or other event in their life. Briefly, this model depends upon adjusting the intensity of the intervention and doing "creative outreach" rather than giving up on a family. Since it appears that more and more programs are lengthening the time of service to a family, the issue of keeping families engaged will take on greater and greater importance.

Goal setting with families is seen as a strength by the programs surveyed. Most programs have moved well beyond deciding what is best for families into a belief that families must be

involved in the process. A greater emphasis on understanding and practicing goal setting with home visitors would help many programs strengthen their interactions with families.

Across the board, supervision is the area in which programs could most strengthen their approaches. Even the outstanding programs in this project seem to have difficulty in providing the time and clinical staff necessary for adequate one-on-one clinical supervision. Programs have less difficulty finding the time to do group supervision. As important and affirming as group supervision is, it cannot take the place of one-on-one clinical supervision in which a professional supervisor works closely and frequently with a home visitor to evaluate observations, strengthen that person's skills, and support the worker in trying additional interventions. Working directly in the home with overburdened families is difficult and stressful. Home visitors deserve the chance to discuss their deepest concerns (about their own work as well as about their families) and to practice their skills privately with a supportive supervisor.

To summarize, Barbara Wasik suggests that, given the high number of paraprofessionals or community workers in the field of home visiting, all programs should conduct periodic training and retraining. On-going training and technical assistance are necessary for all programs in this field, whether their home visitors be professionals or paraprofessionals, volunteers or paid staff. We found programs asking for more training and technical assistance; programs that are "hungry" for new ideas and for the chance to get together with similar workers from across the state to share what they have learned. In order for this to happen, programs are looking for training and technical assistance opportunities specific to the work they do. Many times, we were told, program staff have attended training in California that they thought would address their needs, only to find it was aimed at treatment programs, even though the title led them to believe it was home visit training for prevention and early intervention. Our experience in working with these twenty programs is that the majority of them want additional training in order to ensure that their programs are the best they can be. The three areas specifically considered in this report, as well as the other areas discussed, can and should be addressed on a regular basis by training and technical assistance opportunities of many kinds and by many providers across California. In addition, bringing programs together to share experiences and to share their excitement could only enhance the solid work home visit programs are doing across the state.

"SHE'S GOOD AT DRAWING MY PROBLEMS OUT.
I TRUST HER TO NOT CRITICIZE...
I KNOW SHE'S NOT GOING TO
SCREAM AND YELL AT ME."

Parent

CHAPTER 6

RECOMMENDATIONS

Lisbeth Schorr reminds us that successful programs are both comprehensive and intensive. While this may seem obvious, funding constraints provide powerful pressures to replicate one part of a successful program, even though the original reason for success was the comprehensiveness of the entire program. Also, funding constraints and the burdens of large numbers of families waiting to be served encourages programs to serve families less intensively, even though research as well as anecdotal experiences tell us that families cannot make lasting internal changes quickly.

Truly successful programs invest the time, money and training in staff to support them as they build relationships with families. The values, program culture and the way it is transmitted are understood by successful programs to be as important than the actual services provided. Providing services in a positive, non-punitive manner and believing in the families they serve allows competent home visitors in successful programs to provide flexible, comprehensive, intensive and individualized services to families in the context of their neighborhoods and communities.

In 1993, the American Academy of Arts and Sciences Initiatives for Children hosted a conference on home visiting which included representatives from Hawaii's Healthy Start, Missouri's Parents as Teachers and South Carolina's Resource Mothers as well as home visitors, funders, analysts, researchers, lawyers, pediatricians and community activists. The attendees agreed on five key issues which were:

1. home visiting should be voluntary, client-driven and consumer-based.
2. a universal neonatal home visit should be the foundation of programs which should also include additional voluntary visits and other services for overburdened families.
3. the most important characteristic of home visitors is the capacity to listen well and respectfully while providing support and individualized responses to the family.
4. home visiting programs should be connected with many resources for referral, backup and follow-up.
5. home visiting programs should reflect the community they serve from program conception to implementation.

The face of cutting-edge home visiting has changed over the years. This report recommends that, when considering adding or enhancing a home visit program, funders and providers consider the differences between conventional home visit service delivery and the newer approach, based on research and program experiences, which is more comprehensive, flexible and component based. The conventional approach to home visiting has strict eligibility requirements with little or no attempt to engage hard-to-reach families. The comprehensive approach, whenever possible, offers all parents some support and offers intensive long-term services to those most in need. A process of creative outreach is used to engage the most socially-isolated families, who are often the most overburdened.

The conventional approach traditionally intervenes after a crisis has occurred, when family needs intensify. Services are specific, short-term and treatment oriented. The comprehensive approach uses a systematic needs assessment, usually prenatally or at birth, to determine stress factors and the intensity needed to prevent crises and meet needs early on. Services are flexible, based on a family's needs and are provided on a long-term basis (often for up to three to five years.) In the conventional home visit program, the focus of the program is on an individual and the emphasis is

on correcting family deficits. In the comprehensive approach, the focus of the program is on the entire family, particularly on promoting positive parent-child interaction, with an emphasis on building family strengths.

The overall recommendation of this report is a strong call for more and more-thorough training and technical assistance for programs. Home visitors have personal issues that are important for them to address; there are agency practices and procedures that are important to the success of staff; and home visit programs don't exist in a vacuum - there must also be an awareness of and interaction with other agencies. Home visit programs and home visiting are not for everyone. Home visiting is a specialized position within specialized programs. For example, most people believe in education, but not everyone believes it can be done as well in the home as in the classroom. Home visitors who work in the field of education need to believe this in order to be truly successful. Home visitors must share or facilitate what they believe. This is crucial when one is doing that sharing or facilitating on families' turf. Personal, program, agency and interagency, the needs of home visitors are many. Their strengths are also many, and varied. The challenge of training and supporting such diverse staff can be difficult and overwhelming at times. It can also be extremely rewarding. Being a home visitor can be life-changing. Listening to and working with home visitors who are out there, on the line, doing non-traditional, respectful work with families is also a life-changing, rewarding experience.

'SHE HELPED ME LEARN
TO DO MY LAUNDRY...
MY MOM DIDN'T."

Teen Parent

CHAPTER 7

TRAINING AND CURRICULUM GUIDELINES

When developing training and curriculum guidelines, there are certain philosophical concepts, key concepts and learning objectives that need to be clear to the developer and trainer.

ENGAGING FAMILIES

PHILOSOPHICAL CONCEPTS:

As noted elsewhere, the concept of engaging families begins with the hiring process. However, once staff are hired, the concept of engagement must be taught and supported. Often, programs will find that staff or volunteers have excellent skills at engaging others in social conversations or in building trust with co-workers or friends. These skills can be supported and enhanced through appropriate training and supervision. It is crucial to remember, however, that engaging families (clients) is not quite the same as engaging friends or co-workers. Staff and volunteers must be helped to see the differences that are built in when one party is in a position of power, as program staff and volunteers always are. This supports the need to provide initial and on-going training and practice in this area.

Home visitors and supervisors in this project noted the need for training to reflect the issue of respect - emphasizing respect for a family from "the moment your eyes meet for the first time." Home visitors spoke about the need to connect around strengths, not around problems and the importance of stressing consistency in order to engage families and build trust.

KEY TRAINING CONCEPTS:

Trust
Communication
Family centered approach
Time

LEARNING OBJECTIVES:

Understand the importance of a trusting relationship with families
Understand the reason for and importance of engagement with home-based families
Understand appropriate and inappropriate methods of engagement
Demonstrate appropriate engagement techniques
Demonstrate skills necessary to create an accepting atmosphere

SETTING GOALS WITH FAMILIES

PHILOSOPHICAL CONCEPTS:

The concept of setting and achieving goals has changed dramatically over the past twenty years in the field of home visiting. There was a time when most home visitors set goals for families, usually in the office with their supervisor. Those goals were then presented to the families as non-negotiable. Some programs may still use this practice, particularly programs which deal with families who are already involved in the child abuse system and who have particular court-ordered instructions. Over the years, many programs came to the conclusion that setting goals for families did not always ensure the families' cooperation in meeting those goals. In order to further engage families, programs then turned to letting families set their own goals. While this philosophy certainly engaged more families in the process, it did not ensure that family goals would be related to the reason for the family being in the program. In addition, home visitors were often confused between program goals and family goals. More recently, programs have turned to setting goals with families. This method allows the family to set its own goals, with facilitation and support from the home visitor, and indirectly from the supervisor. Setting goals with families seems to have the best record for engaging families and ensuring long-term, internal changes. However, this method requires that home visitors understand and can articulate and initiate true goal setting in an inclusive manner.

Home visitors and their supervisors in this project noted the need for training to work toward more specific goal-setting, with goals that are achievable. We encourage programs to spend more time on teaching and practicing goal setting with home visitors and supervisors. It cannot be a one-time training, but rather something that is practiced and articulated every week during clinical and group supervision.

KEY TRAINING CONCEPTS:

Goals and objectives
Family support plan
Family strengths
Adult learning

LEARNING OBJECTIVES:

Understand the principles of adult learning
Incorporate adult learning principles into lesson plans
Understand shared goal setting with families.
Understand the principles of building on family strengths

SUPERVISION

PHILOSOPHICAL CONCEPTS:

Supervision in home visiting programs is a necessity in order to provide quality programming for children and families. Working with families in their own homes can be stressful, frustrating, time-consuming and challenging. Home visitors need on-going support and training in order to cope with the demands of the field. In supervision, as with all learning, home visitors learn best when they have a variety of experiences. In home visiting, the optimal model for supervision translates to clinical supervision (weekly one-on-one time with the supervisor to discuss the home visitor's entire caseload,) group supervision (weekly time with the supervisor and several home visitors to discuss issues of interest and concern and to practice presenting cases for discussion,) team meetings (weekly team meetings to discuss administrative and program issues such as time sheets, holidays, etc. and to have training sessions,) and periodic direct observation of the home visitor by the supervisor.

In this project, supervisors spoke of supervision as coming down to issues the home visitors need to confront - often issues of their own. They spoke of the importance of the very strong relationship between the persons they supervise and themselves; about building on the key elements of safety: consistency and trust; and about helping staff to remember their goals during a crisis so that they don't become trapped in the same crisis as the family. Importance was given to the idea of making supervision a metaphor for the ways they would hope to treat families - providing a supportive, nurturing relationship which includes acceptance and understanding, empathy and defining strategies and interventions.

KEY TRAINING CONCEPTS:

Supervision
Team approach
Quality management
Caseload management

LEARNING OBJECTIVES:

Understand the concept of a team approach to supervision
Identify supervision intervention that support a team approach
Understand the concept of appropriate caseload management.
Understand the reasons for clinical supervision, group supervision and team meetings.
Understand quality management theory and techniques
Demonstrate clinical supervision

The three areas discussed above embody critical elements for quality home visiting programs. However, they are only three of many areas in which training needs to be provided though pre-service and in-service modes. Following is a list of areas and knowledge used by Healthy Families America National Trainers in order to provide Healthy Families America supervisors with an overview of the basic areas of knowledge and skills they are responsible for developing in their staff through a basic training program, on-going supervision and in-service training. The list is not meant to be complete and should be added to based on a program's target population and other local factors:

BASIC AREAS OF KNOWLEDGE AND SKILLS FOR HOME VISITORS AS DEVELOPED BY THE HAWAII FAMILY STRESS CENTER AND HEALTHY FAMILIES AMERICA

A. INTRODUCTION TO AGENCY MISSION, ADMINISTRATIVE STRUCTURE, POLICIES, PROCEDURES AND WORK RULES.
   1. Worker will complete agency orientation and follow all policies and procedures.

B. HOME VISITOR JOB ORIENTATION AS DEMONSTRATED THROUGH THE PERFORMANCE OR UNDERSTANDING OF THE FOLLOWING SKILLS AND KNOWLEDGE.
   1. Establish a relationship with parents that allows for open discussion of issues and concerns.
   2. Establish a home visit schedule that is consistent and demonstrates availability to parents.
   3. Understand the potential value of home visit services for all parents, but especially for parents facing more challenges.
   4. Understand the meaning of and can manage a family's reluctance to accept services.
   5. Establish an effective Individual Family Support Plan with families.
   6. Assess a family's lack of knowledge of basic living skills and assist the family in improving their skills in this area.
   7. Prioritize tasks related to service goals.

C. DYNAMICS OF CHILD ABUSE AND NEGLECT.
   1. Understand the variables within families that can result in child abuse and neglect.
   2. Understand the dynamics of mistrust, isolation and low self-esteem and their impact on parent-child interactions.
   3. Understand the different types of abuse and neglect, the most common characteristics of abusive families, and possible consequences of abuse and neglect.
   4. Demonstrate knowledge of available community resources to support families involved in child abuse and neglect.

D. CHILD MANAGEMENT AND DISCIPLINE.
   1. Understand and discuss with families age-appropriate nurturing techniques for the management of children (i.e. crying, biting, feeding, safety, toilet training, temper tantrums and encouragement of play.)
   2. Understand and discuss the differences between discipline and punishment.
   3. Understand and discuss how the emotional needs of challenged parents affect their disciplinary techniques.
   4. Outline alternative methods of discipline that can be taught and modified for parents (i.e. time out.)

E. COMMUNITY RESOURCES.
   1. Familiar with services and community resources available to HFA families.
   2. Offer families a list of available resources with addresses, phone numbers and contact persons.
   3. Assist participants in using helping networks and community resources.

F. COMMUNICATION SKILLS.

1. Demonstrate capacity to use interviewing techniques with participants to include the following:
   * understanding the importance of establishing rapport with participants.
   * initiating relationships and establishing confidence with participants.
   * identifying verbal and non-verbal cues.
   * identifying roadblocks to effective communication.
   * demonstrating active listening and problem-solving skills with parents.
   * using "I messages."
   * using empathy and respect when relating to participants.

2. Understand and apply problem-solving strategies in work and with families.
3. Identify learning styles of parents and incorporate accordingly.

G. INFANT/CHILD GROWTH AND DEVELOPMENT.

1. Understand and discuss the importance of positive attachment and parent-child interaction and demonstrate promoting this with parents of newborns and infants.
2. Use knowledge of stages of physical, social-emotional, language and self-help development in children 0-5 years including developmental milestones.
3. Understand and discuss age appropriate parent-child interactive activities to enhance emotional and physical development that can be taught to or modeled for parents.

H. CULTURAL SENSITIVITY.

1. Understand the importance of cultural sensitivity within ethnic groups served by the program.
2. Recognize similarities as well as differences between staff values and those values held by participants and display respect for the values of others.

I. PROFESSIONAL BOUNDARIES AND LIMIT SETTING.

1. Constantly maintain professional boundaries and set appropriate limits with program participants.

CURRICULUM GUIDELINES

There are many commercial curricula and materials available for home visiting programs to use in their work with families. When selecting a curriculum and materials, attention should be focused on key concepts that help ensure that the curriculum and materials are appropriate, respectful and sensitive to the population served. Curricula vary from extremely prescribed, with each home visitor completing the same task each week with each family, to extremely individualized, with each family visit being different each week.

KEY CONCEPTS:

Interactive with opportunities for discussion
Culturally sensitive
Applicable to families with limited literacy skills
Applicable to families with limited resources
Appropriate to population served
Varied learning experiences
Focus on interaction and bonding between primary caregiver and infant, child or youth.
Comprehensive
Component approach to include parent involvement, resources, mental health, health/medical, nutrition, education, child growth and development, caretaking skills, etc.

A word of caution: Using a very prescribed curriculum may make home visit planning easier for home visitors, but runs the risk of home visitors becoming dependent on the "Commercial Materials Crutch" in which they only use commercially developed materials which cannot be found in the average family's home. Not only does this stifle creativity on the part of the home visitor, it also reduces the chance for individualizing for family needs and it does not provide a way for families to continue the concept of the visit when the home visitor is gone.

"SHE'S GREAT - SOMEONE TO TALK TO -
WHO TAKES THE TIME - THE EXTRA EFFORT.
I WAS REAL DOWN, DIDN'T FEEL LIKE
A GOOD PERSON...SHE SAID
'YOU'RE A GREAT PERSON.'
SHE DOESN'T JUDGE ME,
SHE SUPPORTS ME."

Parent

TABLE 1

MENTOR PROGRAMS

AGENCY: BIENVENIDOS CHILDREN'S CENTER, INC.
PROGRAM: **BIENVENIDOS FAMILY SERVICES**
ADDRESS: 205 E. Palm St., Altadena, CA 91001
PHONE/FAX: (818) 798 7222 (818) 798 8444
CONTACT: Barbara Kappos
CHARACTERISTICS: high-need, low-resource, focus on newborn to 5 years.
HOW LONG: 6 months to several years
HOW INTENSIVE: home visits 1 x week to daily as needed
OTHER SERVICES: center based services and dependency court advocacy
HOME VISITORS: paid staff

AGENCY: CENTER FOR CHILD PROTECTION, SAN DIEGO CHILDREN'S HOSPITAL
PROGRAM: **PARENT AIDE HOME VISITOR PROGRAM**
ADDRESS: 3020 Children's Way, M/C 5016, San Diego, CA 92123
PHONE/FAX: (619) 576 5910 (619) 278 2365
CONTACT: Diana Champion
CHARACTERISTICS: any age: high risk for abuse/neglect/maltreatment, post-incident cases of abuse/neglect, parents w/ childhood hx of abuse.
HOW LONG: 6 months to several years
HOW INTENSIVE: home visits 1 x week with telephone follow-up
OTHER SERVICES: parenting classes, support groups, crisis intervention, counseling, referrals, advocacy, socialization, community education programs, transportation, 24 hour crisis response.
HOME VISITORS: volunteers

AGENCY: CENTER FOR CHILD PROTECTION, SAN DIEGO CHILDREN'S HOSPITAL AND SHARPE/MARY BIRCH HOSPITALS
PROGRAM: **TEEN HOME VISITOR PROGRAM**
ADDRESS: 3020 Children's Way, M/C 5016, San Diego, CA 92123
PHONE/FAX: (619) 576 5910 (619) 278 2365
CONTACT: Diana Champion and Paula Crews
CHARACTERISTICS: teens 13 - 18 yrs: prenatal or at delivery: high-risk for health, age, isolation, abuse hx, dysfunctional families, non-supportive families.
HOW LONG: one year average
HOW INTENSIVE: home visits 1 x week or more
OTHER SERVICES: telephone contact, transportation, infant classes, counseling, advocacy, referrals, support groups w/ child care, crisis intervention, medical, educational, financial.
HOME VISITORS: volunteers and paid staff

AGENCY: CHILD ABUSE AND NEGLECT, INC.
PROGRAM: **HEALTHY FAMILIES VENTURA COOPERATIVE, INC.**
ADDRESS: 2186 Knoll Drive, suite A, Ventura, CA 93003
PHONE/FAX: (805) 644 1555 (805) 644 7643
CONTACT: Estela Montiel
CHARACTERISTICS: women who have recently delivered w/ hx of substance abuse, mental illness, family stress or harsh discipline of baby.
HOW LONG: up to five years
HOW INTENSIVE: initially, home visits 1 x week, later less frequent.
OTHER SERVICES: parent education, resource and referrals
HOME VISITORS: paid staff

AGENCY: COMMUNITY ACTION COMMISSION OF SANTA BARBARA COUNTY
PROGRAM: **COMMUNITY ACTION COMMISSION HEAD START OF SANTA BARBARA COUNTY**
ADDRESS: 5681 Hollister Ave, Goleta, CA 93117
PHONE/FAX: (805) 922 2243 (805) 349 8165
CONTACT: Debby Conn
CHARACTERISTICS: 3 yrs, federal poverty guidelines, special needs, CPS referrals, special cases.
HOW LONG: 8 1/2 months
HOW INTENSIVE: home visits 1 x week
OTHER SERVICES: social services, case conferencing, health/nutrition/dental services, parent training opportunities, family self sufficiency, ESL, literacy.
HOME VISITORS: paid staff

AGENCY: EXCHANGE CLUB CHILD ABUSE PREVENTION CENTER OF ORANGE COUNTY, INC.
PROGRAM: **EXCHANGE CLUB PARENT AIDE PROGRAM**
ADDRESS: 2482 Newport Blvd., suite 7, Costa Mesa, CA 92627
PHONE/FAX: (714) 722 1107 (714) 722 1173
CONTACT: Kathy McCarrell
CHARACTERISTICS: birth through 17 yrs with emphasis on children under 12 yrs: at-risk of abuse, referred by child abuse registry.
HOW LONG: 1 year
HOW INTENSIVE: home visits 1 x week for 4 hours
OTHER SERVICES: referrals to community resources
HOME VISITORS: volunteers and paid staff

AGENCY: THE EYE COUNSELING AND CRISIS SERVICES
PROGRAM: **BRIDGE BUILDERS IN-HOME SERVICES**
ADDRESS: 340 B Rancheros Drive #103, San Marcos, CA 92069
PHONE/FAX: (619) 744 3117
CONTACT: John Hughes and Kimberly Clayton
CHARACTERISTICS: 0-5 years: low income, at-risk of abuse or neglect, referred by medical clinics
HOW LONG: 6 - 12 months
HOW INTENSIVE: home visits 3 x month
OTHER SERVICES: referrals, seasonal parties, volunteer opportunities
HOME VISITORS: paid staff

AGENCY: NEWBORN CONNECTIONS
PROGRAM: **NEWBORN CONNECTIONS**
ADDRESS: P.O. Box 5017, Walnut Creek, CA 94596
PHONE/FAX: (510) 820 2854 (510) 935 0388
CONTACT: Sherry Glueck
CHARACTERISTICS: Last trimester through first 6 months of perinatal period: lack of transportation, teen mother, poverty, family stress, mother who has concerns or questions regarding infant care.
HOW LONG: 12 to 18 months
HOW INTENSIVE: home visits 1 x week or every other week
OTHER SERVICES: resource & referrals, donated clothing and baby equipment
HOME VISITORS: volunteers

AGENCY: SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH
PROGRAM: **S.T.O.P. (SERVICES TARGETED ON PREVENTION)**
ADDRESS: 351 N. Mt. View Ave., San Bernardino, CA 92415-0010
PHONE/FAX: (909) 387 6333 (909) 387 6228
CONTACT: Claudia Spencer
CHARACTERISTICS: 0-14 yrs, at high-risk for abuse/neglect as determined by Child Protective Services.
HOW LONG: 6 months or more
HOW INTENSIVE: home visits minimum 1 x month
OTHER SERVICES: concrete items, transportation, support, parenting services.
HOME VISITORS: paid staff

AGENCY: T.E.A.C.H., INC.
PROGRAM: **HEALTHY FAMILIES MODOC**
ADDRESS: 112 E. 2nd Street, Alturas, CA 96101
PHONE/FAX: (916) 233 3111 (916) 233 4744
CONTACT: Marjorie Shepherd
CHARACTERISTICS: all infants regardless of income, race, religion, who deliver at Modoc Medical Center and live within 10 miles.
HOW LONG: 3 years
HOW INTENSIVE: home visits at least 1 x month; 1 x week to begin
OTHER SERVICES: office visits, transportation, new mothers support group, assessments and referrals to local and regional agencies.
HOME VISITORS: paid staff

AGENCY: W.E.E. C.A.R.E. PARENT INFANT CENTER
PROGRAM: **W.E.E. C.A.R.E. SURE START PRENATAL PROGRAM**
ADDRESS: P.O. Box 1900, Placerville, CA 95667
PHONE/FAX: (916) 626 2868 (916) 622 7853
CONTACT: Julie DeHart
CHARACTERISTICS: Entry point: prenatal period
HOW LONG: up to three years, if needed
HOW INTENSIVE: home visits 1 x week
OTHER SERVICES: case management; transportation, information & advocacy
HOME VISITORS: volunteers and paid staff

TABLE 2

DEVELOPING PROGRAMS

AGENCY:	THE BRIDGE COUNSELING CENTER, INC.
PROGRAM:	**THE FAMILY ADVOCATE PROGRAM**
ADDRESS:	P.O. Box 546, Morgan Hill, CA 95038-0546
PHONE/FAX:	(408) 779 2113 (408) 778 9672
CONTACT:	Saundra Monroe
CHARACTERISTICS:	At-risk parents of newborn to school-age children,: parental stress, teen parents, limited education, at risk of abuse and neglect.
HOW LONG:	12 to 18 months
HOW INTENSIVE:	home visits 1 x week
OTHER SERVICES:	resource and referral information, social gatherings
HOME VISITORS:	volunteers

AGENCY:	CENTRAL VALLEY INDIAN HEALTH, INC.
PROGRAM:	**NEW BEGINNINGS**
ADDRESS:	20 N. DeWitt, Clovis, CA 93612
PHONE/FAX:	(209) 299 2634 (209) 298 2695
CONTACT:	Vanaye Ransom
CHARACTERISTICS:	prenatal - 3 months; first-time, Native American parents
HOW LONG:	2-5 years
HOW INTENSIVE:	home visits 1 x week at first
OTHER SERVICES:	comprehensive perinatal services, parenting classes, childbirth classes, early child care classes, FAS/FAE screening, social services, counseling, psychological services, medical and PHN.
HOME VISITORS:	paid staff

AGENCY:	CHILD ADVOCACY COUNCIL
PROGRAM:	**FAMILIAS UNIDAS/ FAMILIES UNITED**
ADDRESS:	460 California Ave, Palo Alto, CA 94306
PHONE/FAX:	(415) 327 8120 (415) 327 1949
CONTACT:	Bernadette Plotnikoff
CHARACTERISTICS:	families w/ newborns to age 5: CPS referrals, poverty, social stress, health problems, referred by school for attendance or behavioral problems of siblings.
HOW LONG:	6 months to one year
HOW INTENSIVE:	home visits 1 - 2 x week
OTHER SERVICES:	parenting classes, resource information, social gatherings, assistance in seeking medical care
HOME VISITORS:	paid staff

AGENCY: CHILDREN'S BUREAU OF SOUTHERN CALIFORNIA
PROGRAM: **PROJECT L.E.A.R.N. FULLERTON**
ADDRESS: 50 S. Anaheim Blvd., suite 241, Anaheim, CA 92805
PHONE/FAX: (714) 517 1900 (714) 517 1911
CONTACT: Sandy Sladen
CHARACTERISTICS: third trimester through 3 months of age: high risk for abuse/neglect
HOW LONG: three years
HOW INTENSIVE: home visits: birth - 6 months-1 x week; 6-12 months: 2 x month; 12-24 months: 1 x month; 24-36 months: quarterly
OTHER SERVICES: prenatal care, well child care, parenting classes, parent support groups, developmental assessments, resource brokering, 24 hour availability, volunteer special friend.
HOME VISITORS: paid staff

AGENCY: DESERT COUNSELING CLINIC
PROGRAM: **MENTOR MOM**
ADDRESS: 814 N. Norma Street, Ridgecrest, CA 93555
PHONE/FAX: (619) 375 9781 (619) 375 7541
CONTACT: Debra Kinney
CHARACTERISTICS: primary prevention: prenatal and up
HOW LONG: 2 -12 months
HOW INTENSIVE: home visits 1 x week
OTHER SERVICES: parent education classes, link with other services
HOME VISITORS: volunteers

AGENCY: ECONOMIC OPPORTUNITY COMMISSION OF SAN LUIS OBISPO
PROGRAM: **HOME-BASED HEAD START**
ADDRESS: 880 Industrial Way, San Luis Obispo, CA 93401
PHONE/FAX: (805) 544 4355 (805) 549 8388
CONTACT: William Castellanos
CHARACTERISTICS: age 4, low-income or disabilities
HOW LONG: 9 months
HOW INTENSIVE: home visits 1 x week
OTHER SERVICES: group socialization, medical/dental, nutrition/mental health/social services
HOME VISITORS: paid staff

AGENCY: LASSEN INDIAN HEALTH CENTER
PROGRAM: **NEW BEGINNINGS**
ADDRESS: 795 Joaquin Street, Susanville, CA 96130-1719
PHONE/FAX: (916) 257 2542 (916) 257 6983
CONTACT: Tracy Karshner
CHARACTERISTICS: prenatal to 6 months after delivery, Native American parents
HOW LONG: 3-5 years
HOW INTENSIVE: home visits 1 x week at first
OTHER SERVICES: PHN, perinatal services, well baby services, mental health and social services, parenting classes, transportation.
HOME VISITORS: paid staff

AGENCY: SONOMA COUNTY INDIAN HEALTH PROJECT
PROGRAM: **NEW BEGINNINGS**
ADDRESS: 791 Lombardi Court, #101, Santa Rosa, CA 95407
PHONE/FAX: 9707) 544 4056 (707) 526 1016
CONTACT: Dr. Katherine Walker and Carole Lightfoot
CHARACTERISTICS: prenatal, first-time teen age mother, Native American
HOW LONG: 5 years
HOW INTENSIVE: home visits 1 x week to 1 x quarter
OTHER SERVICES: specialized health care, professional counseling, emergency referrals, legal aid referrals, transportation referrals, community resources.
HOME VISITORS: paid staff

AGENCY: WU YEE CHILDREN'S SERVICES
PROGRAM: **HOME-BASED CHILD DEVELOPMENT AND FAMILY SUPPORT PROGRAM**
ADDRESS: 177 Golden Gate Ave, San Francisco, CA 94102
PHONE/FAX: (415) 864 8396
CONTACT: Lynn Barbaree
CHARACTERISTICS: at risk due to isolation, lack of services, living in an extremely high-risk community, substance abuse issues.
HOW LONG: up to three years, if needed
HOW INTENSIVE: home visits at least 1 x week
OTHER SERVICES: referral assistance, translation, infant/child development activities, help for health/social services/ cultural adaptations.
HOME VISITORS: paid staff

TABLE 3

SAMPLE QUESTIONS

Each program we interviewed was unique and was treated in an individualized manner. However, there were some questions that were asked across a number of programs in order to standardize our focus. The questions may have been asked in slightly different ways in different programs, but the object was the same. Following is a sample of questions that were asked across programs:

Tell me about your program.

How do you engage families when you first meet them - how do you get families to "buy in" to your program?

Tell me about some of your most successful ways of engaging families.

Tell me about setting goals in your program.

Do you involve families in goal setting? How?

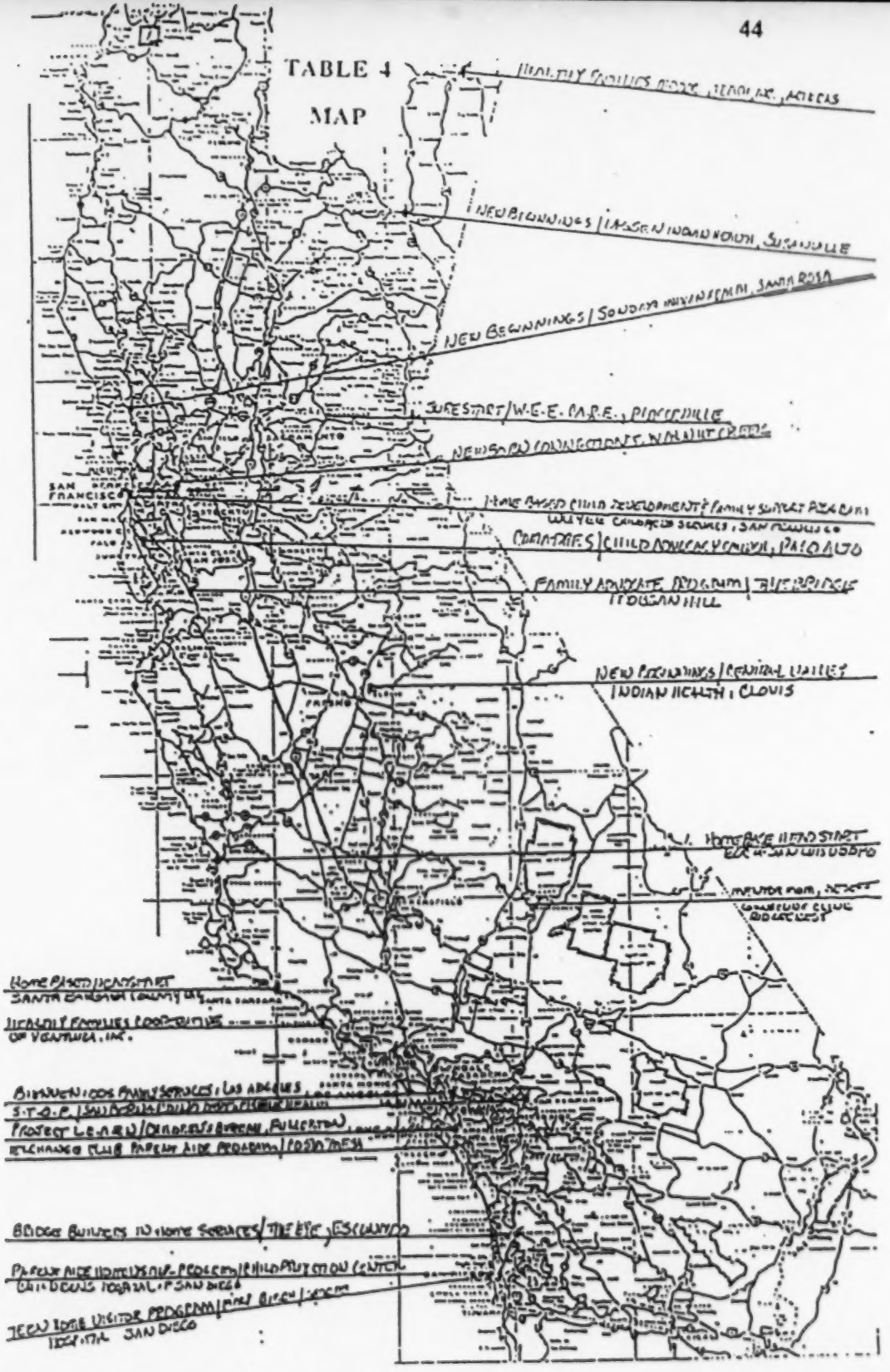
Tell me about the kind of supervision you provide in this program.

Tell me why you chose this kind of work?

If you could have a wish for your program, what would it be?

TABLE 4

MAP


HEALTHY FAMILIES MESA, TEJON, INC., ARVECAS
NEW BEGINNINGS | LAGUNA INDIAN YOUTH, SUSANVILLE
NEW BEGINNINGS | SOUTHERN MINNESOTA, SANTA ROSA
SURESTART/W.E.E. P.A.R.E., PLACERVILLE
NEW SAN FRANCISCO
SAN FRANCISCO
HOME BASED CHILD DEVELOPMENT & FAMILY SUPPORT PROGRAM
CHILDREN'S | CHILD CARE COUNCIL, PALO ALTO
FAMILY ADVOCATE PROGRAM | RIVERSIDE
INDIAN HILL
NEW BEGINNINGS | CENTRAL VALLEY
INDIAN HEALTH, CLOVIS
HOME BASED HEAD START
EOA OF SAN LUIS OBISPO
INFANT MOM, INC.
HOME BASED HEADSTART
SANTA BARBARA COUNTY
HEALTHY FAMILIES COORDINATIVE OF VENTURA, INC.
BIENVENIDOS FAMILY SERVICES, LOS ANGELES
S.T.O.P. | SAN DIEGO CHILD
PROJECT LEARN | CHILDREN'S BUREAU, FULLERTON
EXCHANGE CLUB PARENT AIDE PROGRAM | COSTA MESA
BRIDGE BUILDERS IN HOME SERVICES | THE ARC, ESCONDIDO
PARENT AIDE HOME VISITOR PROGRAM | CHILD ABUSE COUNCIL OF SAN DIEGO
TEEN HOME VISITOR PROGRAM | FAMILY RESOURCE CENTER, LOCATION SAN DIEGO

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